

SERVICE GUIDELINES

for

Speech Therapy in Early Intervention

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This document can be downloaded by visiting
the New Jersey Early Intervention System Web site:

<http://nj.gov/health/fhs/eis/index.shtml>

or

New Jersey Early Intervention Regional Collaborative Web site:

<http://www.njeis.org>



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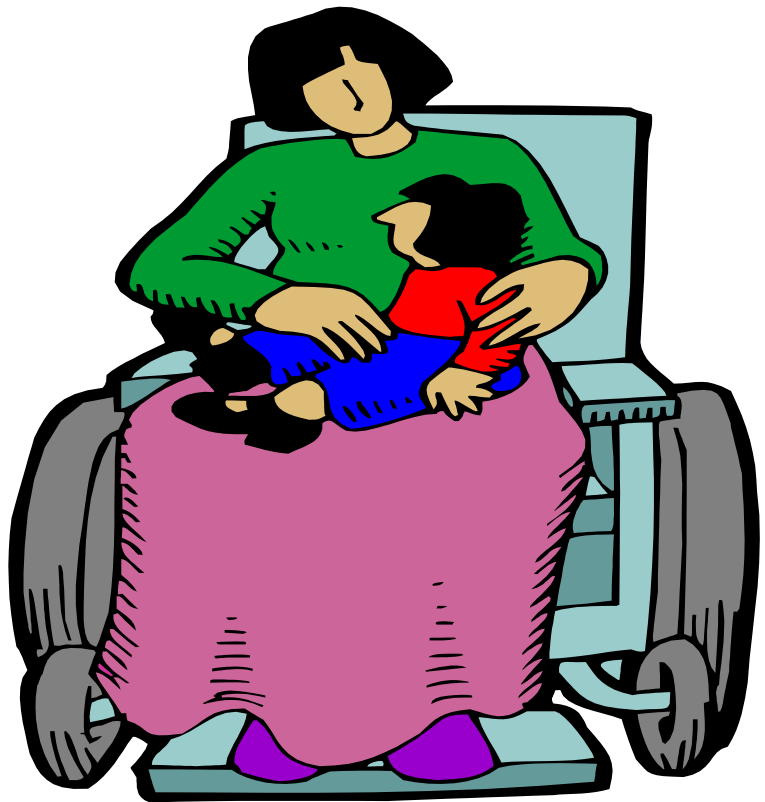
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INTRODUCTION

As lead agency for early intervention in New Jersey, the Department of Health and Senior Services (DHSS) is committed to ensuring the New Jersey Early Intervention System (NJEIS) provides appropriate services to all eligible children and their families. These services are designed to be developmentally appropriate, outcome-based, consistent with federal mandates, and fiscally responsible throughout the state.

DHSS and the New Jersey Early Intervention System are dedicated to the ongoing clinical and professional development of all practitioners who work with young children. To facilitate this goal, DHSS requested the development of best practice guidelines regarding occupational, physical, and speech therapy.

Three dedicated workgroups collaborated with the lead agency to draft guidelines for each discipline that would incorporate shared philosophy, shared practice, and specific discipline implementation. Each set of guidelines reflects a strong commitment to implementing therapy within the broad philosophy of early intervention, while maintaining the integrity of each discipline.

The three groups viewed the implementation of discipline-specific therapy as embedded within the New Jersey Early Intervention System (NJEIS) vision, mission, characteristics, and model of early intervention service delivery. The sections written jointly include philosophy, shared practices, knowledge and skills of evaluators, and clinical competency.

This document contains the guidelines relating to Speech Therapy and its implementation in early intervention in New Jersey. These guidelines are perceived as dynamic and comprehensive but may not be all-inclusive of every detail needed for daily practice.

NOTES

1. The term "**speech therapy**" in this document refers to speech therapy, speech-language therapy, speech-language pathology, etc., by representing most commonly used terms reflective of the scope of practice of speech-language pathology.
2. The document "**Oral Motor Feeding Guidelines**" is being disseminated in draft format and can be downloaded from www.njeis.org.
3. Occupational and physical therapy guidelines may be available in the future.

OVERVIEW OF EARLY INTERVENTION IN NEW JERSEY

The Individuals with Disabilities Education Act (IDEA) is the federal law that ensures children with disabilities, ages 3-21, a Free and Appropriate Education (FAPE) under Part B. Children, aged birth to three years, are served under Part C of IDEA through the New Jersey Early Intervention System. By federal law, there are 5 established functions provided at public expense to children birth to three years of age and their families. They are:

- ❖ Child Find;
- ❖ Evaluation and Assessment;
- ❖ Service Coordination;
- ❖ Development and review of the Individualized Family Service Plan (IFSP), including plans for transition; and
- ❖ Procedural Safeguards.

Federal regulations define early intervention as services that are:

- ❖ "designed to meet the developmental needs of each child eligible ...and the needs of the family related to enhancing the child's development."

Vision Statement

New Jersey will have in place an Early Intervention System which is driven by beneficiaries to provide early intervention services that are equitable, flexible, family-centered, culturally competent, and community-based, coordinated, delivered in natural environments, and are continually improving on each of these characteristics. These system-delivered services will be available, accessible, affordable, and appropriate; and will result in infants, toddlers, and their families having the opportunity to develop, grow, and ultimately, lead productive lives in the community.

Mission Statement

The mission of the New Jersey Early Intervention System is to enhance the capacity of families to meet the developmental needs of children, birth to age three, who have delays or disabilities, by providing quality services and support to families and their children. Families from diverse racial, cultural, and socio-economic backgrounds will be involved in decision-making at every level of the design, implementation, and evaluation of the Early Intervention System. The system will:

- ❖ Provide a family-centered approach based upon the uniqueness of the family and its culture;
- ❖ Promote collaborative partnerships among the family, their community, service and health care providers, school programs, and child care settings that strengthen and enhance family competence to develop and use lasting networks of support;
- ❖ Promote prompt service and support delivery in settings most natural and comfortable for the child and family that foster opportunities for the development of peer relationships with children without disabilities;
- ❖ Reflect the current best practices in the field of early intervention in order to ensure uniformity of service delivery standards to yield the most positive outcomes for the child and family;

- ❖ Recognize and respect the knowledge, beliefs, aspirations, values, culture and preference of families and utilize these for planning and delivery of supports and services; and
- ❖ Facilitate ongoing, system-wide, participatory evaluation to ensure an effective and efficient statewide Early Intervention System.

Characteristics of Early Intervention

Early intervention services are provided to children and their families in ways that help families maximize their children's development, consistent with federal law:

- ❖ Within the family's home;
- ❖ Within the family's natural environments (the home and community settings in which children without disabilities participate);
- ❖ With the active participation of the family;
- ❖ In the language or mode of communication used by the family; and
- ❖ With respect for the family's culture.

Model of Service Delivery

NJEIS believes that developmental growth is nurtured through relationships. The organizational design of NJEIS will reflect and value the importance of parent and child, family-to-family, family and community, family and provider, and other relationships, such that:

- ❖ Supports and services will be provided in a way that
 - Supports the development of relationships among families, their children, their communities, and people who provide early intervention service;
 - Is not limited by roles and professional disciplines (i.e., physical therapy, occupational therapy, speech therapy, etc.); and
 - Is consistent with professional codes of conduct and practice acts;
- ❖ Families are always members of the team and determine their own team roles;
- ❖ Staff and family develop the plan together based on family concerns, priorities, and resources;
- ❖ Team members commit to teach, learn, and work to plan and provide integrated services;
- ❖ Team members carry out their responsibilities in accordance with the plan, collaboratively, and in consultation with other team members; and
- ❖ Team members share responsibility and accountability for how the plan is implemented with the family.

Natural Environments

New Jersey supports and complies with the federal law and regulations that require early intervention services to be provided in the natural environment, to the maximum extent appropriate. Section 303.18 of IDEA defines natural environments as settings that are natural or typical for the child's age peers who have no disabilities. As per section 303.167, NJEIS ensures, that to the maximum extent appropriate, early intervention services are provided in natural environments and that the provision of services for any infant or toddler occurs in settings other than a natural environment only if outcomes cannot be achieved satisfactorily in the natural environment.

The decision of environment should be made by the team with respect for the family's concerns, priorities, and resources, and pattern of interaction with the child. Besides the child's home, there are often other natural environments that could be considered as a possibility for service delivery. These include a child care setting, a family member's home, and other community programs in which children without disabilities participate.

Developmental Intervention

The purpose of providing early intervention services is to promote the child and family's ability to meet the developmental outcomes the family has chosen as their priorities in the Individualized Family Service Plan (IFSP). Developmental intervention can be implemented by qualified practitioners of varying backgrounds who meet NJEIS personnel standards. Regardless of the instructional method, developmental intervention should be a balance between responsive teaching and directive teaching, following a child's lead and ensuring the child responds to specific events, and a balance between self-directed learning and following the agenda of adults (Strain et al, 1998).

Developmental intervention includes (but is not limited to) these types of activities:

- ❖ Working directly with the child;
- ❖ Promoting a positive parent-child relationship as the core of intervention efforts;
- ❖ Identifying activities and daily routines which can be utilized as learning opportunities for the child;
- ❖ Teaching the family to design learning environments and materials to promote the child's acquisition of a variety of skills;
- ❖ Sharing knowledge of child development with families;
- ❖ Coordinating the intervention activities that are provided within the EI team; and
- ❖ Networking with and providing consultation to community providers and friends that the family chooses.



JOINT STATEMENT ON DISCIPLINE-SPECIFIC THERAPY

Speech, Occupational, and Physical Therapy

Developmental intervention, provided by early intervention practitioners, should be based on a strong foundation in child development and early learning. Additional expertise in working with families to help them learn strategies that will facilitate their child's development during natural routines and activities, helps to strengthen developmental activities.

Discipline-specific therapy services are provided by licensed practitioners who demonstrate specific expertise when needed to meet identified developmental outcomes. Discipline-specific therapies and family support services are incorporated into IFSPs based on the child and family's assessment information, therapeutic recommendations, and family input.

The purpose of discipline-specific therapy is to provide targeted strategies to enhance the child/family's ability to meet a developmental outcome in their IFSP.

The need for discipline-specific therapy is determined through an evaluation or assessment by a therapist from the area of concern and is considered by the IFSP team after outcomes are completed. The frequency and intensity of the therapy are determined by the entire IFSP team that considers what is needed to meet the outcomes and how the services will fit into the family's daily routines.

When a child needs developmental intervention AND one or more discipline-specific therapies, services may be provided by one or more professionals. Practitioners are chosen by the early intervention program based on the knowledge, skills, and expertise needed to meet the developmental outcomes on the IFSP. The IFSP team decides whether these services will be provided directly by a discipline-specific practitioner or utilize a consultative model of intervention.



PHILOSOPHY STATEMENT

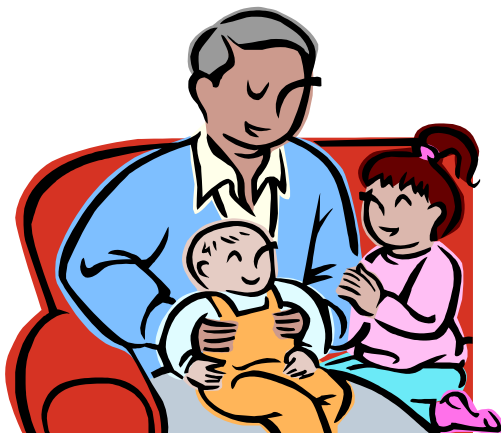
It is recognized that programs move between interdisciplinary and transdisciplinary models for team interaction (McGonigal, et al., 1994). No matter which team interaction model is utilized, service delivery needs to be relationship-based within the context of the family-child relationship. NJEIS believes that developmental growth is nurtured through relationships. The organizational design of NJEIS reflects and values the importance of parent and child, family to family, family and community, family and provider, and other relationships.

The National Center for Family-Centered Care (1990) has defined the key elements of relationship-based service as:

- ❖ Recognizing that the family is the constant in the child's life, while the service system and personnel within those systems fluctuate;
- ❖ Honoring the racial, ethnic, cultural, and socio-economic diversity of families;
- ❖ Recognizing family strength and individuality and respecting different methods of coping;
- ❖ Sharing with parents on a continuing basis and in a supportive manner, complete and unbiased information;
- ❖ Encouraging and facilitating family to family support and networking; and
- ❖ Recognizing that families are always members of the team and determine their own team roles.

Within relationship-based services, all team members, regardless of discipline, share the responsibility for:

- ❖ Helping families connect to the appropriate supports and resources;
- ❖ Designing a plan of care and services that are flexible, respective of cultural diversity, and responsive to family-identified needs, concerns, priorities and resources;
- ❖ Providing services that reflect the current best practice in the field of early intervention;
- ❖ Implementing the plan with the family collaboratively and in consultation with other team members; and
- ❖ Providing integrated services.



SCOPE OF PRACTICE

Scope of practice from the New Jersey Audiology and Speech-Language Pathology Advisory Committee Statutes and Regulations

(These rules were in effect June 2006; for the most updated rules, read current N.J.A.C. 13:44-45):

13:44C-7.2 Scope of Practice--speech-language pathology

The practice of speech-language pathology includes, but is not restricted to, the following functions:

1. Providing screening, identification, assessment, diagnosis, treatment, intervention (that is, prevention, restoration, amelioration, and compensation), consultation, counseling, and follow-up services for disorders of:
 - i. Speech, which includes articulation, fluency, and voice (including respiration, phonation, and resonance);
 - ii. Language, which includes disorders of receptive and expressive communication in oral, written, graphic, and manual modalities;
 - iii. Oropharyngeal and related functions (that is, dysphagia, orofacial myofunctional disorders);
 - iv. Cognitive aspects of communication, which includes communication disability and other functional disabilities associated with cognitive impairment; and
 - v. Pragmatic aspects of communication.
2. Training and supporting family members and other communication partners of individuals with speech, voice, language, and other communication and swallowing disabilities;
3. Developing and establishing effective augmentative and alternative communication techniques and strategies, including selecting, prescribing, and dispensing of aids and devices and training individuals, their families, and other communication partners in their use;
4. Selecting, fitting, and establishing effective use of appropriate prosthetic/adaptive devices for speaking and swallowing (that is, tracheoesophageal valves, electrolarynges, speaking valves);
5. Providing aural rehabilitation and related counseling services to individuals with hearing loss and central auditory processing dysfunction and to their families;
6. Conducting pure-tone air conduction hearing screening and noninvasive tympanometry for the purpose of initial identification and/or referral of individuals with other communication disorders or possible middle ear pathology;
7. Enhancing speech and language proficiency and communication effectiveness, including, but not limited to, accent reduction, collaboration with teachers of English as a second language, and improvement of voice, performance, and singing; and
8. Consulting with educators as members of interdisciplinary teams about communication management, educational implications of communication disorders, educational programming, and classroom accommodations for children with communication disorders.

13:44C-7.2A Scope of Practice: Fiber Optic Endoscopic Examination of Swallowing (FEES)

The purpose of this section is to set forth standards for the performance of Fiber Optic Endoscopic Examination of Swallowing (FEES) by a licensed speech-language pathologist. FEES is within the scope of practice of a speech-language pathologist who meets the requirements of this section.

The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise: "FEES" means a fiber optic endoscopic examination of swallowing.

FEES shall only be performed by a licensed speech-language pathologist who is certified in Basic Life Support (BLS) and who has:

1. Completed a 12-hour seminar or workshop in fiber optic endoscopy as a technique for investigating swallowing which qualifies for American Speech-Language-Hearing Association (ASHA) continuing education credit and which includes instruction in:
 - i. Medical contraindications and possible adverse reactions to FEES, including the use of topical anesthesia to the nares; and
 - ii. Recognizing patient distress and appropriate actions to take if complications are encountered;
2. Observed 10 (ten) FEES procedures performed by either a speech pathologist who has met the requirements of this section or a physician, at a licensed healthcare facility that requires that healthcare professionals have privileges to perform the FEES procedure; and
3. Successfully performed 25 FEES procedures under the supervision of a speech pathologist who has met the requirements of this section or a physician, at a licensed healthcare facility that requires that a healthcare professional have privileges to perform the FEES procedure.

A licensed speech-language pathologist shall only perform FEES in a healthcare facility licensed by the Department of Health and Senior Services or in the office of a physician who received training during residency in endoscopic examination.

FEES shall only be performed when a physician who received training during residency in endoscopic examination is present.

FEES shall only be performed upon the written request of a physician.



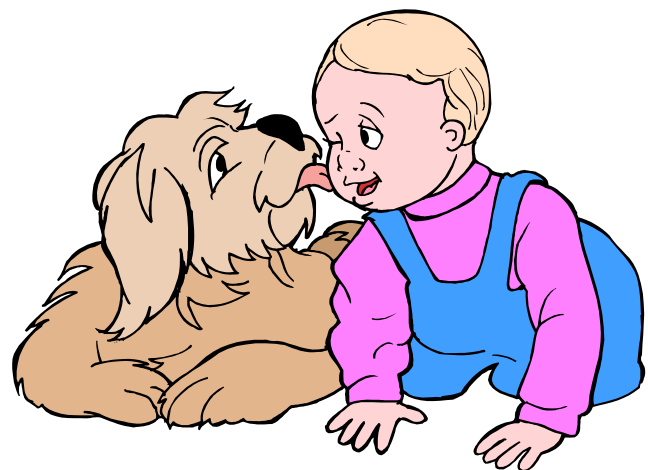
Scope of Practice in Speech-Language Pathology defined by the American Speech-Language-Hearing Association (ASHA), 2001:

For purpose of further elaboration, information regarding the practice of Speech-Language Pathology as defined by ASHA, 2001 is included. The ASHA Scope of Practice includes services that address dimensions of body structure and function, activity, and/or participation as proposed by the World Health Organization Model (WHO, 2000).

The practice of speech-language pathology involves:

- ❖ Providing prevention, screening, consultation, assessment and diagnosis, treatment and intervention, management, counseling, and follow-up services for disorders of:
 - Speech (i.e., articulation, fluency, resonance, and voice including aeromechanical components of respiration);
 - Language (i.e., phonology, morphology, syntax, semantics, and pragmatic/social aspects of communication), includes comprehension and expression in oral, written, graphic, and manual modalities;
 - Language processing, pre-literacy, and language-based literacy skills including phonological awareness;
 - Swallowing or other upper aerodigestive function such as infant feeding and aeromechanical events (evaluation of esophageal function is for the purpose of referral to medical personnel);
 - Cognitive aspects of communication (e.g., attention, memory, problem-solving, executive functions); and
 - Sensory awareness related to communication, swallowing, or other upper aerodigestive function;
- 4. Establishing augmentative and alternative communication techniques and strategies including developing, selecting, and prescribing of such systems and devices (e.g., speech generating devices);
- ❖ Providing services to individuals with hearing loss and their family/caregivers (e.g., auditory training; speech reading; speech and language intervention secondary to hearing loss; visual inspection and listening checks of amplification devices for the purpose of trouble-shooting, including verification of appropriate battery voltage);
- ❖ Hearing screening of individuals who can participate in conventional pure-tone air conduction method, as well as screening for middle ear pathology through screening tympanometry for the purpose of referral of individuals for further evaluation and management;
- ❖ *Using instrumentation (e.g., videofluoroscopy, electromyography (EMG), nasoendoscopy, stroboscopy, computer technology) to observe, collect data, and measure parameters of communication and swallowing, or other upper aerodigestive functions in accordance with the principles of evidence-based practice;
- ❖ Selecting, fitting, and establishing effective use of prosthetic/adaptive devices for communication, swallowing, or other upper aerodigestive functions (e.g., tracheoesophageal prostheses, speaking valves, and electrolarynges); this does not include sensory devices used by individuals with hearing loss or other auditory perceptual deficits;

- ❖ Collaborating in assessment of central auditory processing disorders and providing intervention where there is evidence of speech, language, and/or other cognitive communication disorders;
- ❖ Educating and counseling individuals, families, co-workers, educators, and other persons in the community regarding acceptance, adaptation, and decision-making about communication, swallowing, or other upper aerodigestive concerns;
- ❖ Advocating for individuals through community awareness, education, and training programs to promote and facilitate access to full participation in communication, including the elimination of societal barriers;
- ❖ Collaborating with and providing referrals and information to audiologists, educators, and health professionals as individual needs dictate;
- ❖ Addressing behaviors (e.g., perseverative or disruptive actions) in environments (e.g., seating, positioning for swallowing safety or attention, communication opportunities) that affect communication, swallowing, or other upper aerodigestive functions;
- ❖ Providing services to modify or enhance communication performance (e.g., accent modification, transgendered voice, care and improvement of the professional voice, personal/professional communication effectiveness); and
- ❖ Recognizing the need to provide and appropriately accommodate diagnostic and treatment services to individuals from diverse cultural backgrounds and adjust treatment and assessment services accordingly.



Scope of Practice as it Relates to the Birth to Three Population Within the Early Intervention System:

Utilizing the framework of practice as defined in the ASHA Scope of Practice in Speech-Language Pathology (2001) and Roles of Speech-Language Pathologists in Service Delivery to Infants, Toddlers and Their Families (1989), the overall objective of speech-language pathology services is to optimize and maintain an individual's ability to communicate and/or improve feeding skills in natural environments, and thus improve their quality of life. This objective is best achieved through provision of integrated services in meaningful life context. Speech-language pathologists serve individuals, families, groups and the general public through a broad range of professional activities.

In the field of early intervention, speech-language pathologists assume various roles in addressing the needs of infants and toddlers. These roles include, but are not limited to:

- Screening and identification;
- Assessment and evaluation;
- Design, planning and direct delivery and monitoring of treatment programs;
- Consultation with, and referral to agencies and other professionals providing services to the population;
- Educating and training for families, caregivers, and other professionals;
- Educating, supervising, and mentoring future speech-language pathologists;
- Recognizing the special needs of culturally diverse populations by providing services that are free of potential biases, including the selection and/or adaptation of materials to insure ethnic and linguistic sensitivity; and
- Fostering public awareness and outreach to other community professionals on speech, language, hearing and swallowing, and other upper aerodigestive disorders and their treatment(s).

Practices that are specific to the Speech-Language Pathologist related to provision of direct speech therapy services:

- ❖ Providing screening, consultation, assessment, treatment, management, counseling, and follow-up of services for the disorders of:
 - Speech (i.e., articulation, fluency, and voice, including respiration, phonation, and resonance);
 - Language (i.e., phonology, morphology, syntax, semantics); and
 - Swallowing or upper aerodigestive functions such as infant feeding, oral motor development, and oral pharyngeal and related functions (i.e., dysphagia, oral motor development, oral-facial, and myofunctional disorders);
- ❖ Assisting families in understanding the need for evaluation and interpretation of findings from specific testing conducted for communication, swallowing, audiological, and other upper aerodigestive functions by collaborating with other health care professionals;
- ❖ Collaborating with health care professionals in selecting, fitting, and establishing effective use of prosthetic/adaptive devices for communication, swallowing, or other upper aerodigestive functions (e.g., speaking valves, obturators, tracheoesophageal prostheses);

- ❖ Increasing awareness of potential behaviors, and future testing for the assessment of central auditory and language processing disorders;
- ❖ Educating, consulting, and counseling individuals, families, co-workers, educators, and other persons in the community regarding acceptance, adaptation/accommodation, and management implications of speech, voice, language, hearing, and other communication, swallowing, and/or other upper aerodigestive disorders;
- ❖ Collaborating and providing referrals and information to audiologists, educators, and health professionals as individual needs dictate; and
- ❖ Conducting pure-tone air conduction hearing screening and non-invasive screening tympanometry for the purpose of initial identification and/or referral of individuals with other communication disorders or possible middle ear pathology (in early intervention, an audiologist is usually involved in this process).

Practices that are shared with all Early Intervention Practitioners:

- ❖ Collaborating and providing information and referrals to educators and health professionals as needed;
- ❖ Assisting the family's understanding of specific diagnoses and their impact on child development; and
- ❖ Educating and counseling families, co-workers, and other persons in the community regarding acceptance, adaptation, and decision-making regarding developmental delays/disabilities and their impact on child development.

Practices that remain within the scope of speech therapy, but are included in the scope of practice for other disciplines:

The intent of shared practice is not to cross train other professionals to provide services that are solely within the scope of practice of the speech-language pathologist. It is to highlight that many professionals from other disciplines have the clinical training, skills, and knowledge in areas that may overlap another scope of practice. The practitioner selected should have the necessary clinical skills and knowledge base to assist the child/family in achieving their outcomes. The most appropriate practitioner is determined by considering the findings from evaluation and assessment, as well as family concerns and priorities. It is the responsibility of the early intervention provider agency to have knowledge of the specific range of clinical skills and clinical training of each practitioner, as well as to have an understanding of the scope of practice and licensing/certification regulations for each discipline represented in the agency.

Shared with Special Educator:

- ❖ Provide screening, consultation, treatment, and management to the individuals, their families, caregivers, and other communication partners for:
 - Pragmatics, social aspects of language (e.g., turn-taking, joint attention, eye contact);
 - Language stimulation for verbal development of language, prelinguistic skills;
 - Language comprehension
 - Language expression (including manual and picture modalities);

- Pre-literacy and language-based literacy (e.g., attention or exposure to books, pictures, and other printed materials; listening to stories; following sequence of events);
- Cognitive aspects of communication (e.g., attention, memory, problem-solving, object permanence, cause and effect); and
- Effective augmentative and alternative communication techniques and strategies.

Shared with Teacher of the Deaf:

- ❖ Provide screening, consultation, treatment, and management to the individuals, their families, caregivers, and other communication partners for:
 - Hearing loss (e.g., auditory training, total communication, auditory-verbal training, speech reading, phonetic cueing, intervention secondary to hearing loss, visual inspection, and listening checks of amplification devices for the purpose of trouble-shooting, including verification of appropriate battery, voltage, education and use of amplification devices).

Shared with Occupational Therapist:

- ❖ Provide screening, consultation, treatment, and management to the individuals, their families, caregivers and other communication partners for:
 - Sensory disturbances related to communication, oral motor, swallowing, and other aerodigestive functions.

Shared with Behavior Specialist, Occupational Therapist, and Special Educator:

- ❖ Provide screening, consultation, treatment, and management to the individuals, their families, caregivers, and other communication partners for:
 - Addressing behaviors (e.g., perseveration, disruptive actions, sensory seeking, inattention) that affect communication and feeding.

Shared with Occupational and Physical Therapist, and Special Educator:

- ❖ Provide screening, consultation, assessment, treatment, and management to the individuals, their families, caregivers, and other communication partners for:
 - Positioning, (e.g., seating, swallowing safety, attention, toy access) physical access, and techniques/strategies to utilize augmentative and alternative communication devices, as well as assistive devices (e.g., switches, adaptive equipment, and feeding utensils).



Referrals

Children's health and safety are of critical importance. In addition, issues of liability should also be considered. All early intervention practitioners should be cognizant of the need for medical clearance related to medically fragile infants and toddlers. This may include children with cardiac, feeding, neurological, pulmonary, and/or respiratory concerns or conditions. Clinical judgment should be exercised in these and in any other situations where non-routine medical treatment has been performed. When working with infants and toddlers, the early intervention practitioner may determine through clinical observation and ongoing assessment, that a child is exhibiting symptoms or behaviors that indicate the need for referral(s) to other health care and educational professionals. In accordance with the discipline-specific scope of practice, it is the therapist's responsibility to clearly identify, educate, and work collaboratively with the child's primary care provider to ensure that necessary medical assessments and testing are completed. Many of these symptoms and behaviors can be related to a number of conditions and can be observed by many disciplines involved with the child.

Therefore, it is important to work as a team to discuss observations, impact on the child's development; intervention strategies, and the level of family concern in determining appropriate next steps. If the behaviors exhibited are of significant concern and are related to specialists outside the early intervention system, the family should be advised to consult with their primary care physician for further discussion and the need for specialists. Referrals may also be made to professionals within the early intervention system. When written information is received from a referral source, the appropriate early intervention practitioner should review findings and initiate discussion with referral sources as needed.

Frequently identified behaviors/symptoms that may need referral, include:

Allergist:

- ❖ Chronic congestion, rashes
- ❖ Chronic eczema
- ❖ Chronic feeding problems
- ❖ Constipation/diarrhea
- ❖ Dark circles under the eyes
- ❖ Facial swelling
- ❖ Itching
- ❖ Vomiting

Audiologist:

- ❖ Chronic otitis media
- ❖ Inconsistent responses to voice and environmental sounds
- ❖ Speech-language delay

Behavior Specialist/Psychologist/Social Worker:

- ❖ Chronic aggressive, injurious behaviors to self and others
- ❖ Complicated feeding history including trial of varied intervention techniques with minimal or no response
- ❖ Excessive or lack of attachment/ bonding issues
- ❖ Selective mutism
- ❖ Unique family challenges and stresses that are associated with raising a child with special needs

Endocrinologist:

- ❖ Excessive fatigue
- ❖ Excessive hyperactivity
- ❖ Excessive thirst
- ❖ Metabolic concerns
- ❖ Slow weight gain in spite of adequate food consumption

Gastroenterologist:

- ❖ Chronic diarrhea
- ❖ Chronic flatulence
- ❖ Concerns with food absorption
- ❖ Food refusal
- ❖ Frequent waking from sleep
- ❖ Signs of discomfort during or after feeding (vomiting post-feeding, arching, volume limiting as day progresses, constipation)
- ❖ Weight gain and/or growth issues

Geneticist:

- ❖ Abnormalities of hands/feet
- ❖ Atypical muscle tone
- ❖ Craniofacial abnormalities (eyes, ears, nose, mouth)
- ❖ Familial history of developmental delays

Neurologist:

- ❖ Pervasive delays across the following developmental areas: communication, play, social interactions
- ❖ Soft signs and history that are suggestive of an undiagnosed neurological condition
- ❖ Suspect cranial nerve involvement
- ❖ Suspect seizure disorders: signs can include staring, waking up screaming in the night, chronic tremors, recurring idiosyncratic behaviors associated with onset of episode

Nutritionist:

- ❖ Metabolic disorders
- ❖ Food allergies
- ❖ Limited variety in diet
- ❖ Weight gain and/or growth issues

Occupational Therapist:

- ❖ Delays in self-help skills, including feeding and dressing
- ❖ Difficulty in receiving and processing variety of sensory input (i.e., suspected difficulty tolerating loud noises, touch, olfactory, vestibular, visual stimuli, proprioceptive)
- ❖ Focusing/attention difficulties
- ❖ General fine motor delays
- ❖ Hyper- or hyposensitivity in the oral area
- ❖ Inability to cross midline
- ❖ Questions regarding hand positioning
- ❖ Regulatory concerns
- ❖ Sleep issues and/or sleep disturbances
- ❖ Motor planning issues
- ❖ Upper extremity involvement and/or activity problems utilizing upper extremities

Optometrist:

- ❖ Holding objects very close or avoiding close work
- ❖ Inaccurate reach towards objects
- ❖ Lack of visual fixation by three months
- ❖ Persistent lack of the eyes moving in concert or the sustained crossing of one eye after four to six months
- ❖ Rubbing or blinking excessively
- ❖ Squinting, closing, or covering one eye
- ❖ Turning or tilting the head or body when performing tasks
- ❖ Unable to follow moving objects with eyes

Ophthalmologist:

- ❖ Asymmetry of pupillary size
- ❖ Drooping of an eyelid
- ❖ Frequent horizontal or vertical jerky eye movements (nystagmus)
- ❖ Lack of a clear, black pupil (i.e., haziness of the cornea, a whitish appearance inside the pupil)
- ❖ Persistent redness of the normally white conjunctiva
- ❖ Persistent tearing when the infant is not crying
- ❖ Significant sensitivity to bright light (photophobia)

Otolaryngologist (Ear, Nose & Throat Specialist - ENT):

- ❖ Abnormal vocal quality of resonance
- ❖ Chronic congestion
- ❖ Chronic otitis media
- ❖ Chronic upper respiratory infections
- ❖ Constant runny nose
- ❖ Dark circles under eyes
- ❖ Drooling
- ❖ Enlarged tonsils
- ❖ Mouth breathing
- ❖ Sleep problems including snoring, frequent waking
- ❖ Tight/short frenulum

Neurodevelopmental Pediatrician:

- ❖ Global developmental delays

Pediatric Dentist/Oral Surgeon:

- ❖ Abnormal/missing dentition
- ❖ Jaw abnormalities
- ❖ Tight/short frenulum

Physical Therapist:

- ❖ Adaptive equipment needs
- ❖ Atypical gait patterns
- ❖ Lower extremity involvement
- ❖ Positioning problems
- ❖ Gross motor delays
- ❖ Muscle tone abnormalities and/or muscle weakness

Psychologist:

- ❖ (see Behavior Specialist)

Pulmonologist:

- ❖ Atypical changes in respiration during feeding
- ❖ Color change during feeding and activity
- ❖ Fatigue/endurance issues during feeding
- ❖ Frequent upper respiratory infections or pneumonia
- ❖ History of chronic aspiration
- ❖ Shallow breathing
- ❖ Weak cough or cry

Social Worker

- ❖ (see Behavior Specialist)

Special Educator:

- ❖ Attention-focusing difficulties
- ❖ Behavior management concerns that are interfering with learning
- ❖ Concerns with development of play skills and social interactions
- ❖ Cognitive delays
- ❖ Parenting



CLINICAL COMPETENCY

In addition to the knowledge and skills for an early intervention practitioner as an evaluator, one would need to demonstrate the following abilities. It is recognized that these skills and knowledge develop over time and ongoing mentoring and support of early intervention staff is recommended to obtain and maintain these skills.

General Knowledge and Skills of Early Intervention Practitioners

General skills

- ❖ Asking questions regarding child's typical routines, as well as how the child's developmental concerns impact the family;
- ❖ Sharing all information with family by being sensitive and respectful of the family's concerns and responses, even if the information is likely to cause parental distress;
- ❖ Incorporating information gathered about family priorities into the IFSP by assisting the family to identify family and child outcomes, supports, activities; and the family role in achieving outcomes;
- ❖ Developing outcomes, activities, and strategies with the family that are unique to the child's age, history, developmental profile and the family's priorities, concerns, and resources;
- ❖ Assisting family in identifying potential learning opportunities that occur during the child and family's day that could be utilized to meet outcomes;
- ❖ Describing shared responsibility between practitioners and the family for achieving outcomes;
- ❖ Assisting family in understanding the philosophy of early intervention - able to describe the rationale for a specific type of service, (e.g., when specific expertise is or is not needed to achieve outcomes);
- ❖ Demonstrating the ability to provide early intervention service that:
 - Is child-directed, not therapist-directed;
 - Is individualized, not test-driven;
 - Leads from a strength-based, not a deficit-based approach;
 - Can incorporate toys and materials from the child's environment;
 - Incorporates developmentally appropriate practices and therapeutic strategies into daily caregiving, facilitated by early intervention practitioners and family;
 - Explains the purpose of an activity and describes how the activity relates to the child and/or family needs;
 - Analyzes and modifies environmental support measures (positioning aids, light, sound control) and individualized caregiving procedures;
 - Works within the child's daily routines and employs intervention strategies that fit into the family's activities;
 - Involves other family members, friends, and peers into intervention activities;
 - Understands each parent/caregiver's preferred learning style;
 - Provides continued family education and anticipatory guidance through written home programs and ongoing verbal instructions that facilitate and enhance carryover on a full basis by the family;
 - Addresses new concerns/celebrations for both the child and family; and
 - Enhances child/parent interaction and attachment;

- ❖ Utilizing appropriate documentation methods to record sessions with child and family;
- ❖ Abandoning own individual agenda if the child and/or family are not responding;
- ❖ Acting as a coach;
- ❖ Contributing to the development of transition plans during the time child and family are in early intervention, including transition to early childhood services at age 3;
- ❖ Assisting and supporting the family in the transition process and planning;
- ❖ Remaining aware of community support resources and agencies;
- ❖ Identifying opportunities to link family to other community resources and supports;
- ❖ Understanding and implementing team approaches to intervention (i.e., interdisciplinary model, transdisciplinary model);
- ❖ Collaborating with early intervention team to develop and modify the IFSP for each child;
- ❖ Utilizing other disciplines for support and demonstrating ability to embed strategies from other disciplines into intervention activities;
- ❖ Accepting feedback from other team and family members in order to remain successful in meeting the outcomes;
- ❖ Displaying willingness and the ability to reflect clinical and relationship-based best practices;
- ❖ Negotiating conflict/disagreements appropriately;
- ❖ Remaining cognizant of own feelings and value judgments and how they impact intervention techniques;
- ❖ Displaying willingness to discuss own feelings and judgments openly in supervision meetings;
- ❖ Understanding and implementing the policies and procedures of NJEIS and employer agency; and
- ❖ Applying universal precautions at all times.

Clinical Skills of a Speech-Language Pathologist

General Skills

- ❖ Facilitating the choice of a service delivery model with the IFSP team, using parent concerns and priorities to guide the design and implementation of intervention and ongoing assessment of the child;
- ❖ Making appropriate recommendations regarding frequency, duration, and location of speech therapy services;
- ❖ Planning with family how to integrate intervention activities into the child's and family's daily activities;
- ❖ Providing strategies to families during daily routines to foster and/or facilitate proper positioning of the infant and toddler (i.e., swaddling, side lying, high chair, etc.);
- ❖ Demonstrating ability to appropriately recommend therapy materials, positioning aids, adapted toys, and adaptive feeding equipment, alternate communication systems, and/or assistive devices;
- ❖ Developing criteria for ongoing tracking of outcome achievement;
- ❖ Developing skills regarding the respiration, phonation, and swallow of medically fragile infants and toddlers;

- ❖ Demonstrating ability to anticipate a child's potential for injury (falling, aspiration, choking); and
- ❖ Demonstrating ability to perform a home safety check and provide family with objective recommendations.

Specific Clinical Skills

Oral Motor/Feeding

- ❖ Demonstrates knowledge of:
 - Basic anatomy and function of oral-facial structures;
 - Other systems/medical issues as they relate to oral motor development (i.e., respiration, gastrointestinal [GI]);
 - Progression of food, taste, texture, temperature, and consistency;
 - Stages of swallowing;
 - Testing that could rule in/rule out feeding issues;
 - Tactile system, sensory disturbances, and muscle tone as they relate to oral motor development and feeding issues;
 - Appropriate positioning equipment needed for feeding;
 - Specialized equipment to promote feeding/oral motor development;
 - Techniques and strategies to develop feeding skills;
 - Different types of non-oral feeding techniques (i.e., gastrostomy tube [G-tube], jejunum tube [J-tube], nasogastric tube [NG-tube]) and how this impacts transitioning to oral feeds;
 - Non-verbal communication cues during feeding;
 - Autonomic cues of a child pre-, during and post-feeding;
 - Need to refer family to primary medical care provider to discuss further medical testing;
 - Techniques to decrease drooling; and
 - Interrelationship between oral motor development, feeding development, and motor, cognition, and sound development.

Speech Disorders

- ❖ Demonstrates knowledge of:
 - Developmental sequence of sound production and typical errors versus disordered speech;
 - Anatomy/physiology of oral-motor structures and/or function and related musculature;
 - Relationship of muscle tone to sound development;
 - Impact of hearing loss; chronic ear infections, fluids, and/or allergies on speech development;
 - Relationship between motor planning issues and speech disorders; and
 - Relationship between cognitive delays, (i.e., lack of imitation) and speech development.

Language Disorders

- ❖ Demonstrates knowledge of:
 - Relationship between play and language development;
 - Differences between language delay versus language disorder;
 - Form, content, and use of language, (i.e., syntax, semantics, and pragmatics);
 - Techniques to stimulate language development;

- Various augmentative communication systems currently available; and
- Relationship between motor planning issues and language development.

Voice Disorders

- ❖ Demonstrates knowledge of:
 - Need to refer to primary medical care provider;
 - Characteristics associated with vocal abuse and/or voice disorders;
 - Techniques to remediate issues related to vocal abuse and/or voice disorders; and
 - Effects of allergies/chronic upper respiratory infections and reflux on voice.

Medically Fragile Disorders

- ❖ Demonstrates knowledge of:
 - Relationship among respiratory, pulmonary, and cardiac systems and developmental issues;
 - Management of oral secretions;
 - Prognosis and management of individual medical issues;
 - Application of universal precautions; and
 - Effective ways of collaborating with nurses caring for the child.

Craniofacial

- ❖ Demonstrates knowledge of:
 - Associated genetic or non-genetic disorders and/or syndromes;
 - Surgical interventions (i.e., types and timing);
 - Possible effects on feeding, speech, language, and/or hearing; and
 - Anatomy and physiology of associated structures and muscle innervations.

Sensory

- ❖ Demonstrates knowledge of:
 - Sensory systems, their function, and impact on communication, feeding, and/or speech development;
 - Basic sensory techniques and ability to incorporate into session as instructed by an occupational therapist;
 - Questions to ask a family to determine possible sensory disturbance issues; and
 - Behaviors related to potential sensory disturbance issues.

Fluency

- ❖ Demonstrates knowledge of:
 - Differences between typical versus atypical dysfluencies.

Autism Spectrum Disorders (ASD)

- ❖ Demonstrates knowledge of:
 - Diagnostic and Statistical Manual (DSM) criteria and disorders along the autism spectrum;
 - “Red flags” of ASD, (cognition, behavior, play, social-emotional, sensory processing, and communication);
 - Behaviors that may be consistent with ASD or other etiologies (i.e., sensory processing);
 - NJEIS state guidelines, intervention methodologies, and philosophies for children with ASD, and knowledge of engagement;
 - Management of difficult/inappropriate behaviors;

- Alternative communication systems available (i.e., PECS); and
- When to refer the child and family to a neurologist, developmental pediatrician, and/or neurodevelopmental pediatrician.

Hearing Impairments

- ❖ Demonstrates knowledge of:
 - Anatomy/physiology of the outer, middle, and inner ear;
 - Types of hearing loss;
 - Testing measures used to diagnose hearing loss;
 - Types of hearing aids and function;
 - Treatment methodologies related to cochlear implants;
 - Use of sign language;
 - Impact of chronic middle ear infection/fluid on hearing system;
 - Need for referral to Ear, Nose, and Throat Specialist (ENT) and/or audiologist;
 - Characteristics of deaf speech;
 - Processing of auditory stimuli; and
 - Use of auditory trainers.

Evaluation and Assessment

Knowledge and Skills for an early intervention practitioner as an evaluator:

An early intervention practitioner who is part of an evaluation team should have a thorough understanding of the New Jersey Early Intervention System mission, vision, policies, and procedures and the ability to convey this information to families. Understanding of the New Jersey Early Intervention System should be reflected in clinical practice. It is suggested that an early intervention evaluator have a minimum of three years experience working with children from birth to 5 years, and a minimum of 1 year experience working as a practitioner within the New Jersey Early Intervention System. The practitioner should demonstrate an understanding of family-centered care principles and ability to implement those principles in practice as part of their general competencies. Evaluators should have current certification in cardiopulmonary resuscitation.

To be a member of an evaluation team, an early intervention practitioner should be competent in the following areas:

General Knowledge

- ❖ Identifying child and caregiver needs in the home and other community settings;
- ❖ Understanding environmental, physical and sociocultural risk factors and their influence on the development of infants and toddlers;
- ❖ Conducting pre-handling observation of the child to determine a safe and effective approach to examination and intervention in conjunction with other examiners;
- ❖ Assessing and documenting range of motion, tone, and strength through observation of movement; and gross, fine, and communicative abilities appropriate to age, and how they affect performance on tasks;
- ❖ Calculating adjusted age level;

- ❖ Identifying children at risk for neurological, musculoskeletal, and/or cardiopulmonary difficulties;
- ❖ Understanding common medical conditions and their potential for impact on developmental skills;
- ❖ Understanding contraindications and precautions for specific diagnoses;
- ❖ Understanding medical terminology and abbreviations;
- ❖ Utilizing evaluation/assessment information to determine initial strategies based on an individual child's strengths and motivations;
- ❖ Managing physiological stress in an infant or young child by interpreting autonomic responses (heart rate, respiratory rate and breathing pattern, color, oxygen saturation, blood pressure, and temperature); and
- ❖ Adapting easily to unexpected situations.

Child Development Knowledge

- ❖ Possessing a solid foundation in the understanding and identification of typical and atypical developmental sequences across all developmental areas;
- ❖ Understanding and explaining the relationship between a developmental delay in one area and its impact on other areas of development;
- ❖ Understanding the developmental milestones for child's chronological age; and
- ❖ Identifying and interpreting infant engagement (self-calming) and disengagement (overstimulation), behavioral cues reflected in movement and postures, behavioral state, attention, and interaction.

Testing Process

- ❖ Maintaining competency in the use of a variety of testing instruments (the list is representative, not all-inclusive):
 - Battelle Developmental Inventory, Second Edition (BDI-2);
 - Developmental Pre-Feeding Checklist;
 - Early Intervention Developmental Profile, Vol. 2, Developmental Programming for Infants and Young Children;
 - Early Learning Accomplishment Profile (E-LAP);
 - Goldman-Fristoe Test of Articulation-2 (GFTA-2);
 - Hawaii Early Learning Profile (HELP) Strands (0-3);
 - Infant Scale of Communicative Intent;
 - Infant-Toddler Developmental Assessment (IDA);
 - Modified Checklist for Autism in Toddlers (M-CHAT);
 - Neonatal Neurobehavioral Examination (NNE);
 - Preschool Language Scale, Fourth Edition (PLS-4);
 - Receptive-Expressive Emergent Language Test, Third Edition, (REEL-3); or
 - Rossetti Infant-Toddler Language Scale;
- ❖ Selecting appropriate evaluation and assessment methods, instruments/tools, environments, and equipment;
- ❖ Utilizing clinical observations to interpret the child's behaviors for the family members so they understand the child's overall developmental profile (i.e., explaining the relationship between sensory disturbances and communication delays);
- ❖ Following the child's lead;
- ❖ Reading a child's cues to facilitate engagement;

- ❖ Utilizing effective interviewing techniques to elicit information about the family priorities, concerns, challenges, strengths, and resources.
- ❖ Observing and interpreting the child and family behaviors within interactions and utilizing this information to better understand the child and family needs and developmental concerns;
- ❖ Reading a family's cues and adjusting behavior accordingly to help the family participate in the process;
- ❖ Possessing the ability to observe while actively listening and interacting with the child/family/evaluation team member(s);
- ❖ Building upon information obtained by another evaluation team member and synthesizing information obtained from external evaluation/assessment reports;
- ❖ Working collaboratively with other evaluation team members;
- ❖ Remaining impartial while honoring and respecting different opinions and feelings expressed by various family members;
- ❖ Identifying strategies that family/caregivers have successfully implemented to enhance the child's development; and
- ❖ Attempting remediation strategies during the evaluation process to determine their feasibility for the child and family.

Interpreting and Sharing Results

- ❖ Understanding the point of view of the family or caregiver and their expectations for child development;
- ❖ Interpreting and organizing findings and information for both spoken and written formats and sharing "bad news" in a clear and sequential manner;
- ❖ Delivering findings in a professional, sensitive and respectful manner;
- ❖ Assisting the family in recognizing the child's strengths, which are utilized as part of IFSP development and intervention;
- ❖ Demonstrating ability to build a bridge between family expectations and a child's developmental profile;
- ❖ Assisting in the identification of potential family and child outcomes and how the family will participate in achieving the outcomes;
- ❖ Communicating developmental sequences necessary to achieve the outcomes specified by the family; and
- ❖ Identifying further assessment needs both within and outside of the Early Intervention System.

Guidelines for:

Inclusion of a Speech-Language Pathologist as part of the initial evaluation team to determine need for speech therapy services:

- ❖ Intake information includes:
 - Primary concern is in the area of speech and language;
 - Characteristics suggestive of autistic spectrum disorder;
 - Feeding concerns;
 - Hearing concerns;
 - Symptoms of failure to thrive;
 - Craniofacial anomalies; and/or
 - Intelligibility of speech concerns.

Speech therapy assessment prior to initial IFSP development when Speech-Language Pathologist was not part of initial evaluation team:

- ❖ Language was appropriate but difficult to understand;
- ❖ Feeding issues were identified;
- ❖ Expressive language level was higher than receptive language level;
- ❖ Oral motor planning might be the reason for communication delay;
- ❖ Abnormalities were noted in oral structure and function;
- ❖ Potential hearing loss identified; and/or
- ❖ Lack of speech or babbling.

Assessment by a Speech-Language Pathologist for a child currently enrolled in early intervention:

- ❖ Expected progress has not occurred in the area of communication;
- ❖ Cognitive development has progressed but language skills are developing at a slower pace;
- ❖ Characteristics of autistic spectrum disorder are exhibited, (i.e., absent joint attention, no pointing, limited communicative intent, high-pitched screeching, limited jargon patterns and/or repetitive jargon patterns);
- ❖ Signs of apraxia with oral motor planning difficulties for speech are exhibited (i.e., difficulty imitating tongue/lip movements or sounds on command, limited consonant sound production);
- ❖ Lack of speech clarity;
- ❖ Words are limited to labels;
- ❖ Family or another team member expresses speech/language/feeding concerns;
- ❖ Feeding issues have been identified (i.e., transitioning from bottle/breast to cup or from puree to table foods);
- ❖ Need for alternative forms of communication;
- ❖ Communicative intent or pragmatics concerns;
- ❖ Need for assistive technology or adaptive equipment for feeding;
- ❖ Oral motor concerns related to structure and function; and/or
- ❖ Muscle tone issues impacting respiration/phonation systems.

When an assessment/evaluation is performed by a speech-language pathologist outside the Early Intervention System, those reports should be reviewed by a NJEIS speech-language pathologist. This review helps to determine if the information shared in the report should be considered as part of the eligibility process and/or ongoing assessment of needs. For a child currently enrolled in early intervention, continued eligibility is determined through ongoing assessment of the child's developmental strengths and needs. When a child no longer meets the eligibility criteria, an IFSP review of the child's progress, developmental level, and next steps should be discussed. An outcome should be developed with the family to define the activities and timeline needed to assist the family in transitioning out of NJEIS. Frequency and duration of service through the transition process are based on the specific needs of that child and family. In most cases, the transition should be completed within one to three (1-3) months.

APPLICATION OF SCOPE OF PRACTICE GUIDELINES TO INTERVENTION

Speech Therapy vs. Developmental Intervention

In making a decision regarding appropriate services for a child demonstrating communication delays, it is important to consider the child's entire profile. The profile includes information on a child's developmental strengths and needs at time of assessment, environmental/psychosocial factors, medical status, and other therapeutic services received inside and outside the Early Intervention System and familial history. After completion of the evaluation and/or assessments, consideration of all the information is necessary. It is not uncommon for children with communication delays to also present with other areas of need and concern. This may include sensory disturbance or motor planning issues, cognitive delay, etc.

Team discussion needs to occur to analyze all underlying contributing factors to the presented communication delay, swallowing and/or upper aerodigestive concerns to determine the appropriate services to be provided. A child who presents with a communication delay may not automatically require speech therapy services.

Factors such as the age of the child, the severity of overall developmental delay as it relates to the communication delay, and the child's cognitive status and type of speech-language disorder(s) should be given particular emphasis in the decision-making process. Other factors to consider include supportive services, language of the family, extended family support, community supports, medical involvement, other early intervention services, etc.

It is important to use all information available to make a preliminary decision regarding the need for speech therapy.

Children who appear to be "Late Talkers"

Research studies are trying to identify reliable predictors that would differentiate late talkers from children with language disorders. The following predictors are currently being considered through clinical studies (McCathren, et al. 1996).

The referenced studies attempted to determine which children presenting with language delays between 18 – 24 months, would be most likely to "catch up" in their language development and which children would likely continue to demonstrate ongoing language/learning problems. Although most studies to date focus on children up to 24 months, most researchers agree this information can be applied to children up to 36 months. While there is no unanimous agreement among researchers as to the reliability of predictors (identified list follows) for any individual child, studies have shown that as a group, these early predictors have helped to distinguish "late talkers" from children who will have ongoing language concerns. These predictors may be considered in the decision-making process regarding when to initiate therapy.

If NOT demonstrated, the following factors are predictors identified in **children birth to 18 months for possible language delay** (McCathren, et al. 1996):

Babbling

- ❖ Frequency and complexity of the babbling can help predict future use of meaningful speech, vocabulary, and phonological development.

Development of Pragmatic Functions

- ❖ During the prelinguistic stage of language development in the first year of life, a child should develop the following pragmatic functions:
 - Behavioral regulation – controlling another person's behavior to get them to do something for you.
 - Social interaction – gaining attention from an individual for social reasons.
 - Joint attention – sharing and shifting attention with another to an activity, person, or object.

If NOT demonstrated, the following factors are predictors identified in **children above 18 months for possible language delay**:

Vocabulary Comprehension

- ❖ Understanding spoken words.

Development of Combinatorial and Symbolic Play Skills

- ❖ During the first 3 years of life, play develops from:
 - Exploratory (banging, shaking);
 - Functional (i.e., cup to mouth, push a car, roll a ball);
 - Combinatorial (relating one object to another) (i.e., building a tower and putting a person or toy on top); and
 - Symbolic (use of an object in place of another).

Use of Gestures

- ❖ Utilizing gestures to communicate ideas, wants, needs, etc.

Demonstrates Progress in Development of Language

Possible indicators of continued language delay in children who are chronologically between 18-36 months

- ❖ Developmental intervention is the recommended service when a child with a speech-language delay exhibits only a few of the indicators from the list. The child is more likely to develop age appropriate speech and language skills.
- ❖ The more indicators that exist, the more likely it is for the child to have ongoing speech-language delays. However, for the younger child, developmental intervention is the recommended initial service with monitoring for continued progress. As the child is approaching 28 months and limited progress has been demonstrated, a speech-language assessment is recommended to determine the need for speech therapy.

- ❖ For the child who enters the system at or above 28 months of age with multiple indicators from the list, speech therapy needs to be involved. Method and frequency of the speech therapy services should be based on the evaluation and assessment, clinical judgment of the speech-language pathologist, and the child's communication profile. Developmental intervention should also be considered if the child's social, play, and imitation skills are delayed.

SPEECH/LANGUAGE	NON-VERBAL
<u>Language Production</u> <ul style="list-style-type: none"> ❖ Particularly small vocabulary for age ❖ Less diverse vocabulary, particularly in regard to verbs ❖ Preponderance of general all-purpose verbs (do, make, want, go) ❖ More transitive and fewer intransitive verbs (give ball) <u>Language Comprehension</u> <ul style="list-style-type: none"> ❖ Presence of 6-month comprehension delay ❖ Large comprehension-production gap with comprehension deficit <u>Phonology</u> <ul style="list-style-type: none"> ❖ Few prelinguistic vocalizations ❖ Limited number of consonants ❖ Limited variety in babbling structure ❖ Fewer than 50% consonants correct (substitution of glottal consonants and back sounds for front) ❖ Restricted syllable structure ❖ Vowel errors <u>Imitation</u> <ul style="list-style-type: none"> ❖ Few spontaneous imitations ❖ Reliance on direct model and prompting in imitation tasks of emerging language forms 	<u>Play</u> <ul style="list-style-type: none"> ❖ Primarily manipulating and grouping ❖ Little combinatorial and/or symbolic play <u>Gestures</u> <ul style="list-style-type: none"> ❖ Few communicative gestures, symbolic gestural sequences, or supplementary gestures <u>Social Skills</u> <ul style="list-style-type: none"> ❖ Behavioral problems ❖ Few conversational initiations, interactions with adults more than peers ❖ Difficulty gaining access to activities <u>Health and Family History</u> <ul style="list-style-type: none"> ❖ Recurrent otitis media ❖ Family history of persistent problems in language learning
<p>Adapted from: Clinical Practice Guideline: Report of the Recommendations. Communication Disorders, Assessment, and Intervention for Young Children (Age 0-3 years) New York State Department of Health Early Intervention Program</p>	

Through evaluation and assessment, if many of these indicators **ARE present**, speech therapy should be the service provided to address the communication outcomes.

The onset of speech development can vary dramatically, even with typically developing children. Although a child may be “slow” in the development of speech and language, progress should be noted monthly. Progress may be demonstrated by behaviors such as increasing the variety and frequency of sound production, initiating a new word, using a word for a variety of functions, beginning to combine words, or using word(s) or phrases more frequently.

If over time, through ongoing assessment and monitoring, continued growth in the development of language is not demonstrated, the child should be reassessed by a speech-language pathologist to determine the need for direct speech therapy intervention.

Children with speech-language delays and delayed prelinguistic skills

Prelinguistic skills are the foundation for language development. A child need not have acquired all the prelinguistic skills listed below, however, it is expected that the majority of the skills are either present or emerging, particularly those that are *italicized*. The *italicized* skills are considered critical to the development of language. If the *italicized* components are missing or severely delayed, developmental intervention is recommended to first address the acquisition and/or emergence of these foundational skills:

- ❖ Attention to environment
- ❖ Self-regulation (i.e., ability to regulate arousal and attentional levels for learning)
- ❖ *Attention to speech*
- ❖ Cause and effect
- ❖ *Communicative intent* (initiation and response to communicative attempts)
- ❖ *Functional object play*
- ❖ *Imitation*
- ❖ *Joint attention*
- ❖ Means/End
- ❖ Object permanence
- ❖ Pragmatics of language
- ❖ Problem-solving
- ❖ Symbolic presentation
- ❖ Turn-taking

The following are explanations of the **five critical skills**:

❖ ***Attention to Speech***

- Implies acknowledgment of the speaker. This acknowledgment can take many forms such as looking at a speaker, moving towards or withdrawing from speaker, or ceasing an activity momentarily in response to speech.

❖ ***Communicative Intent***

- Displays message through a variety of means, including crying, yelling, pushing, gesturing, vocalizing to initiate and sustain interactions, to regulate the behavior of those in their environment.

❖ **Functional Object Play**

- Moves beyond undifferentiated play with objects (i.e., mouthing and banging) to differential play with objects according to their function (i.e., comb to hair).

❖ **Joint Attention:**

- Shares and shifts attention from one activity, person, or object to another.

❖ **Imitation:**

- Able to reproduce motor and vocal movements.

Children with Expressive Language Delay only

- ❖ For a child less than 28 months with an expressive language delay and intact cognition, receptive language, and motor skills, developmental intervention is the recommended appropriate service.
- ❖ For a child at or above 28 months, speech therapy services should be provided. Method and frequency of the speech therapy services should be based on the evaluation and/or assessment, clinical judgment of the speech-language pathologist, and the child's communication profile. Services can be consultative or direct.
- ❖ For a child who demonstrates behaviors associated with possible motor disorders such as, dyspraxia or dysarthria, phonological issues, or craniofacial anomalies, speech therapy services should be initiated. Method and frequency of the speech therapy services should be based on the evaluation and/or assessment, clinical judgment of the speech-language pathologist, and the child's communication profile. Services can be consultative or direct.

Children with Speech-Language Problems Associated with other Developmental Problems

Speech-Language Problems and General Delays

- ❖ If an overall speech-language delay is significantly greater than the overall level of developmental delay:
 - speech therapy should be initiated if the child has intact pragmatic and prelinguistic skills. (i.e., child's chronological age [CA] is 24 months; overall developmental level is 18 months; developmental language level is 14 months; child has joint attention, gestural system, etc.).
 - if the prelinguistic and pragmatic skills are delayed, developmental intervention is the appropriate service.
- ❖ If the child's receptive language level is significantly below the expressive language level, even if overall language level is commensurate with overall developmental delay, speech therapy should be initiated. (i.e., language processing).
- ❖ If the child has a speech-language delay associated with:
 - Motor disorders (dyspraxia, apraxia, dysarthria);
 - Craniofacial anomalies; and/or
 - Phonological processing, then speech therapy should be initiated.
- ❖ If the child has a cognitive delay commensurate with a receptive and expressive delay, developmental intervention should be the recommended service.

Hearing Impairment and no other Developmental Delays

- ❖ If the child has hearing issues or concerns, audiology or other medical intervention needs to be conducted prior to determining the need for speech therapy services. Developmental intervention is more appropriate while information is being obtained and medical intervention is being provided.
- ❖ Services by a speech-language pathologist or a Teacher of the Deaf should be initiated for a child with speech-language problems determined to be the result of a hearing loss (i.e., conductive hearing loss consistent with middle ear pathology, cochlear implant, or children with a severe/profound hearing loss).
- ❖ Speech therapy needs to be initiated for a child with a diagnosis of a severe or profound hearing loss, and the child is attempting to use oral versus sign language communication.

Sound Development Concerns

- ❖ If speech intelligibility is significantly reduced as a result of oral motor deficits, speech therapy is recommended, assuming phonological processes are not typical for child's age.

Developmental Delays and Oral Motor/Feeding Issues

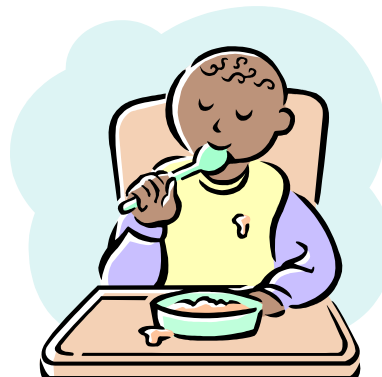
- ❖ If a child feeds orally, but is delayed or disordered in feeding skills, the oral-motor/feeding specialist (usually a speech-language pathologist) should make a determination whether further medical assessment and/or clearance is necessary before implementing strategies to address feeding issues. For the child who is a non-oral feeder, medical clearance is considered best practice before implementing strategies to address any oral motor or feeding concerns. Information may also be identified regarding the feeding issues (i.e., metabolic disorder, food allergy, failure to thrive diagnosis). The oral motor/feeding specialist should make a determination whether medical clearance is needed before strategies that implement introduction of appropriate quantities of food. Speech-language pathologists should be a member of the assessment team in determining if a speech-language pathologist is needed to address swallowing and/or other upper aerodigestive disorders. Speech therapy, as a consultative or direct service when addressing these disorders, is recommended.
- ❖ If the oral motor/feeding issue impacts the child's ability to produce sounds and use language, speech therapy should be initiated.
- ❖ If the oral motor/feeding issue impacts other developmental areas (i.e., self-help, social/emotional, sensory system, motor development), developmental intervention is initiated or another discipline-specific service may be recommended based on the needs identified from evaluation and/or assessment.
- ❖ If the child has nutritional and/or oral motor/feeding needs that are medical in nature, and they are not affecting the child's development, then the child does not meet the defined eligibility criteria for services in the NJEIS.

Primary Language is not English

- ❖ For a child who is recently adopted from a foreign country – if the child is developing at age-appropriate levels in all areas and language skills are age appropriate in their native language, the child is typically not exhibiting a developmental delay and would not be eligible for early intervention.
- ❖ If child presents with any developmental delays in association with speech-language delay, refer to information above regarding developmental delays.

It is important to recognize that the factors for initiating speech therapy versus developmental intervention may change over time, as children continually grow and develop. Ongoing assessments of the child's communication and other developmental areas are necessary to evaluate the continued appropriateness of the services defined in the Individualized Family Service Plan and progress toward outcomes.

In cases where the behavior or symptoms are indicative of a more severe condition requiring intensive rehabilitative services outside the NJEIS model of enhancing a family's capacity to meet the developmental needs of the child, outpatient services should be considered and discussed with the family. We recognize that the New Jersey Early Intervention System model may not be what a parent is seeking, and, therefore, clinical rehabilitative service delivery should be reviewed and discussed.



METHODS OF SPEECH THERAPY SERVICE DELIVERY

In New Jersey, the speech-language pathologist works as part of an interdisciplinary and/or transdisciplinary team to provide early intervention services. According to the NJ Licensure Act, Speech-Language Pathologists provide service delivery through Consultation, Direct, or Indirect Services to children who are delayed or disabled with respect to communication, language, speech or oral-motor development, and their families. These terms are defined below with examples for their use in early intervention: (ASHA Technical Report, 1989, p. 63).

- ❖ “Direct service” is defined as speech therapy techniques individually designed and provided by a speech-language pathologist or temporary licensed speech-language pathologist to an infant or toddler and their family.
- ❖ “Consultative service” refers to the provision of expert or professional advice to a client or other interested party with regard to therapeutic activities or approaches, which may be utilized in order to evaluate the effect of some aspect of the child’s communicative, language, speech, or oral motor development; to modify a particular program; to enhance other professionals’ abilities to incorporate communication, language, speech or oral-motor strategies as part of their sessions; to increase public awareness regarding speech, language, social-communicative and oral-motor problems; and offer various strategies for prevention and remediation.
 - (i.e.) The speech-language pathologist may design a program to help a child or assist a child to transition from smooth purees to table foods that can be carried out by parent, professional, or other caregiver. The Speech-Language Pathologist would participate in periodic review to assess progress.
- ❖ “Indirect support” is defined as speech therapy techniques that are individually designed, but which do not require direct interaction with infants/toddlers and their family, for the purpose of directing or advising others in therapeutic activities or approaches which may be used in order to improve the communicative performance of the client.
 - (i.e.) The speech-language pathologist reviews a treatment plan with another team member and provides activities and strategies to incorporate communication and/or oral-motor activities into the treatment session.



DETERMINATION OF METHODOLOGY AND FREQUENCY OF SPEECH THERAPY

After comprehensive evaluation, assessment, IFSP outcomes, and strategies have determined the need for speech therapy, the next step includes determining the method of service delivery and frequency of speech therapy services.

All factors that affect the child's current functioning level and individual prognosis for progression should determine the frequency of services and the method of service delivery. Recommendations are made as part of a team including family members, service coordinator, provider agency personnel, and an evaluation team member.

Factors to Consider in Decision-Making Process for Determination of Frequency

- ❖ Prognostic factors (i.e., diagnosis, cognitive abilities) that impact the child's potential for obtaining new skills;
- ❖ Age of the child;
- ❖ Severity of the developmental delay(s);
- ❖ Changes in the child's development over time;
- ❖ Services received outside of the Early Intervention System;
- ❖ Early intervention services currently in progress and the skills and knowledge of the early intervention practitioner(s) already working with the child and family;
- ❖ Level of participation of family and/or caregiver;
- ❖ Strategies the family has already implemented with the child;
- ❖ Family's level of anxiety or discomfort regarding the child's needs;
- ❖ Presence of prerequisite skills for language development;
- ❖ Family resources and supports;
- ❖ Significant change(s) in the child's medical status that may impact on functioning;
- ❖ Familial history; and
- ❖ Opportunities for engagement in the home and community.

Speech Therapy as a Direct Service is appropriate when:

- ❖ Child needs the skills that only a speech-language pathologist can provide. Please refer to Scope of Practice Section and Application Section for further information.

Speech Therapy as a Consultative Service is appropriate when:

- ❖ Primary caregiver and/or practitioner need suggestions for:
 - Stimulating language;
 - Developmental sequences as they relate to language, speech, or oral motor/feeding;
 - Progressing through various feeding stages or appropriate feeding equipment;
 - Monitoring child's progress in speech, language, oral motor/feeding;
 - Concerns regarding medical/community referrals;
 - Appropriate positioning related to feeding;
 - Using augmentative communication system(s);
 - Providing input to staff in child care or community settings to optimize child's participation in those activities; or
 - Sharing knowledge and information regarding the child's needs with other professionals or community.

Speech Therapy as an Indirect Support:

- ❖ Indirect support affirms the philosophy that development is transactional and interrelated. A child needs to be viewed as a whole and not segmented into developmental areas. Indirect support is provided through team collaboration and clinical discussion. Indirect support can lead to high clinical quality, best practitioners, and excellent services.
- ❖ It is meant to:
 - Support the practitioner's understanding of the child's needs;
 - Foster collaboration when issues are clinically challenging;
 - Provide suggestions for strategies and activities;
 - Develop a team member's transdisciplinary skills;
 - Explore possible interpretations or hypotheses for exhibited behaviors;
 - Determine need for referrals;
 - Provide emotional support to each other as team members;
 - Reflect on a practitioner's feelings and concerns that may impact working with the family;
 - Clarify procedures and/or policies of the system and/or the employer agency; or
 - Increase awareness about community supports and resources.

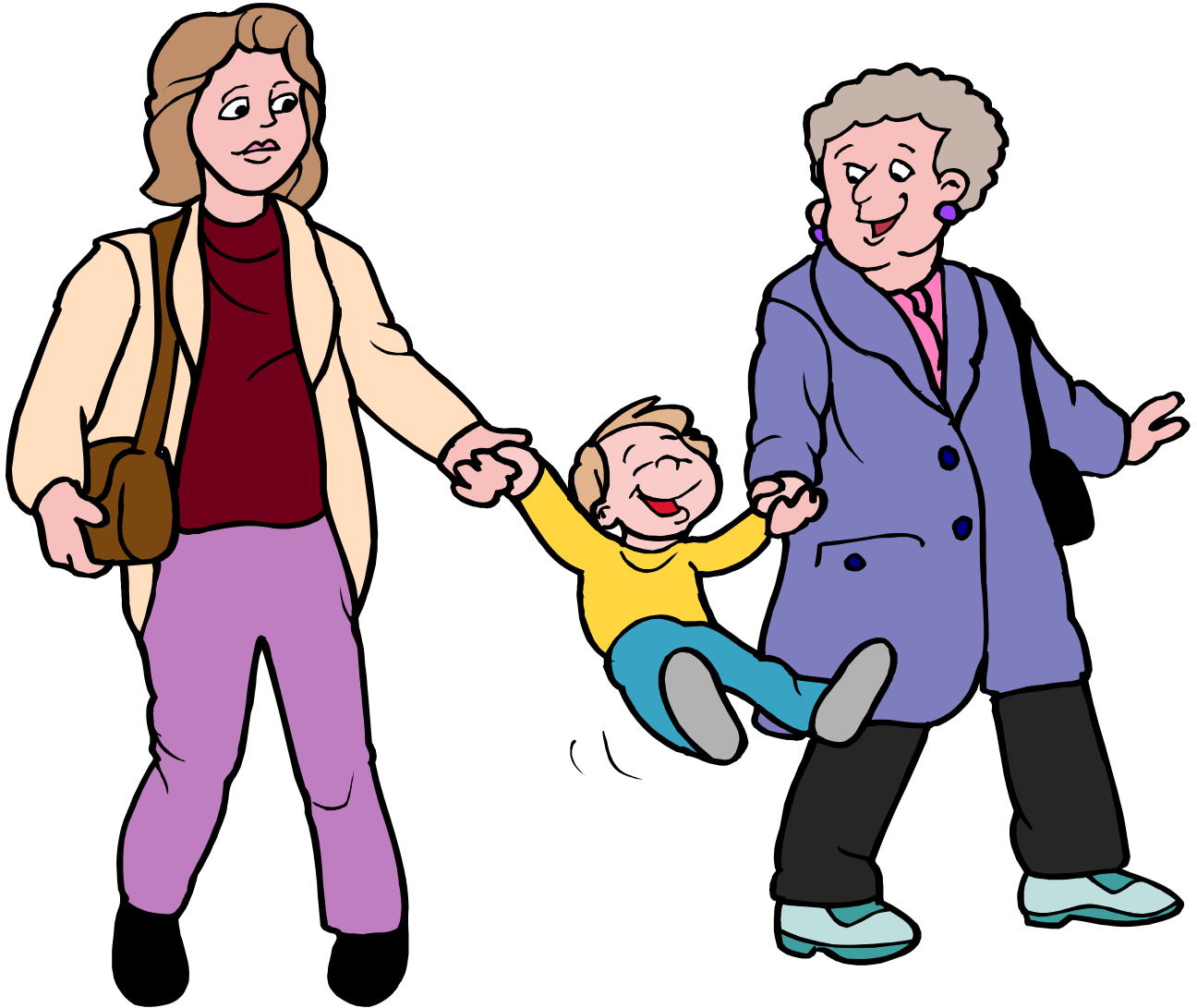
**Method and frequency of
speech therapy services in early intervention
should be based on
evaluation and/or assessment,
outcomes developed by the IFSP team,
clinical judgment of the speech-language pathologist,
early intervention philosophy,
and the child's communication profile.**

Services can be consultative or direct.



Concluding Remarks

In compiling the guidelines put forth in this document, the NJEIS has spent considerable time and attention to balancing the needs of all those who will be directly affected by them, including children and families, NJEIS personnel, and the constituents of New Jersey. These guidelines will be monitored in the coming months and years for their effectiveness in meeting the objective they were intended to meet: to assist service coordinators, practitioners, and families in designing quality early intervention for young children with developmental delays and their families.



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